

## CHAPTER 1

# Child psychiatry and the people who have shaped it

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‘The greatest terror a child can have is that he is not loved, and rejection is the hell he fears. And with rejection comes anger, and with anger some kind of crime in revenge for the rejection, and with the crime guilt – and there is the story of mankind.’

John Steinbeck, *East of Eden*, 1952

John Steinbeck was centrally concerned with social exclusion, and the story of child and adolescent psychiatry has also shared this focus. It begins with the delinquent child and only later includes children with other behavioural and emotional problems. Often depending on private charity and voluntary organisations, marginalised children and young people in Britain had little to help them, and services were scattered before the establishment of the National Health Service (NHS) in 1947. In the USA, the specialty grew from a turbulent period of mass migration and social change in the 20th century, but it was aided by important European influences.

The origins of child psychiatry derive from a convergence of theories and practice from public health and paediatrics, asylum psychiatry, psychoanalysis, psychology, social work, education and criminology. This has led to richness from one point of view but confusion from another (Parry-Jones, 1994). It has also resulted in problems in defining the work of child psychiatry and what child psychiatrists do. Some 20 years ago, Parry-Jones commented ‘Many questions bear on the future of the subspecialty, concerning its scope, its place in psychiatry and medicine, and issues about staff roles and organization’ (Parry-Jones, 1994: p. 794), and these matters are just as pressing for the professional today. Often it can seem that child psychiatrists, just like Dr Martin Dysart in Peter Shaffer’s 1973 play *Equus*, are struggling with their own sense of purpose while trying to understand the complex or perplexing patients they are trying to help.

When child guidance clinics were founded in the UK, the aim was to prevent delinquency and antisocial behaviour. There may well have been a deficiency of theoretical orientation behind this desire: the team-working approach encouraged diplomacy and integration but, in the words of Evans *et al*, it ‘brought about a marked loss in terms of maintaining theoretical coherence and accuracy’ (Evans *et al*, 2008: p. 469). There was, however, a

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hope, expressed by the Maudsley's first superintendent Edward Mapother in 1932, that a study of these children would produce recorded information of *how mental illness began* (Evans *et al*, 2008: p. 456) (my italics).

There is evidence now of increasing interest in child and adolescent psychiatry and its history. The public health importance of emerging disorders, the need for special education in many circumstances, public attitudes towards delinquency, crime and disability, and a social history involving significant developments in the interwar period are all reasons for this. And there is the abiding conflict between nature and nurture which makes many of the clinical cases child psychiatrists deal with so richly interesting.

Some of the seminal changes that have occurred in psychiatry in general, and in child psychiatry in particular, are still within the lifetimes of psychiatrists working today, so that 'There is a zone in history where the past merges with the present' (Crammer, 1990: p. 175). The formation of the Royal College of Psychiatrists in 1971 and the NHS reorganisation of 1974, which effectively led to the closure of the asylums, number among these changes. As this book goes to press, the ramifications of another large change, the Health and Social Care Act 2012, will be beginning to be felt.

In almost every decade there has been at least one useful historical review by a clinician, and sometimes several. Examples of these are the excellent guide by Barton Hall (1947), and those by Rosen (1968: pp. 285–300), Warren (1971), Hersov (1986) and Wardle (1991), the latter containing many serviceable chronological tables. Parry-Jones's (1994) scholarly review is both tightly structured and comprehensive. Black & Gowers (2005) provide a briefer overview, and Cottrell & Kraam (2005) an understanding of more contemporary developments in service organisation.

More recent studies by non-clinicians such as Evans *et al* (2008) make interesting additions to this body of work and introduce new questions. By examining patients' notes, management accounts and types of treatments available, this study is unusual in describing how practice influenced the growth of the specialty, rather than adopting a primarily critical approach emphasising medicalisation, accidental discoveries and the inherent weaknesses of classification systems so prominent in other historical and political accounts.

## Developmental history

So the beginning of this story will be in the 1850s, when the term paediatrics was first used to describe the study of infant and child health in Europe, perhaps reflecting a concern with national efficiency and strength in that period. For example, the context of the military losses of the Franco-Prussian war (1870–1871) may have been instrumental in the emergence of infant welfare clinics in France (Levene, 2011). Indeed, war came to play a significant part in the history of the development of the discipline in Europe.

In the 1850s in Britain most kinds of insanity were still confined to the asylum. At a time when literature about children in English life (*Jane Eyre* and *Wuthering Heights* were published in 1847 and *David Copperfield* in 1850) was beginning to emerge, some children were incarcerated as a matter of course. Although it is not widely recognised, children as young as 5 were admitted to asylums (Parry-Jones, 1990). Of 46 young people under the age of 16 admitted to Oxfordshire County Asylum between 1846 and 1866, 25 were recorded as having epilepsy, 19 were classed as idiots, 2 were hallucinating, 4 had delusional ideas, 2 were paranoid, 1 was thought to be manic and several were suicidal.

The development of child and adolescent psychiatry through child guidance to what is now known as child and adolescent mental health followed slightly different paths in the USA and Britain. In the USA, according to several authors (Barton Hall, 1947; Rosen, 1968: pp. 285–300), maladjustment appeared to be a growing topic of public interest in the early part of the 20th century. The reasons for this are probably complex but two factors stand out: this was a time of extraordinary migration to America, with total immigration soaring to more than 8 million individuals in 1901–1910, most of whom settled in the cities. During this period too, children were still labouring in industrial workplaces, which no doubt required their full contribution to the labour force. In the powerful photographs of the social reformer Lewis Hine, such as *Little Spinner in Globe Cotton Mill*, 1909, or *Noon Hour in the Ewen Breaker*, 1911, we see images of children working in filthy and perilous conditions.

In this context we find reference to an early psychiatric clinical study of delinquent youth begun in 1909 and culminating in *The Individual Delinquent* (1915), by William Healy (1869–1963) (cited by Barton Hall, 1947), and it appears that at this time a psychiatric lens was beginning to be applied to delinquency elsewhere as well. Rosen (1968: pp. 285–300) reports that by 1932, 50 cities in the USA had established clinics for such children.

Along the way, certain publications can be seen to have shaped developments. In 1914, for example, the Children's Bureau recommended the need for establishing good, regular habits early, and to this end in 1921 the Baby Hygiene Association of Boston joined forces with the psychiatrist Douglas Thom to form a Habit Clinic. Children between the ages of 2 and 5 with undesirable habits were managed with the combined force of professionals from psychiatry, psychology and social work (Rosen, 1968: pp. 285–300).

### *The child guidance clinic*

So it was that we arrive at a pivotal period in the story of our specialty's development. During the decade 1920–1930 the child guidance clinic emerged in the USA, focused on problem children and with the objective of treatment and rehabilitation. A team approach was used and the systemic paradigm adopted that the child's problem was symptomatic of a troubled family and social situation.

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In Britain meanwhile, and in a somewhat parallel development, in 1923, the year of its opening, London's Maudsley Hospital had only a small department for the treatment of children, run by Dr W. S. Dawson with the help of the hospital almoner. The strategic goals of the institution set out in 1907 made no reference to the treatment of children, so the provision of children's services had not been planned. However, from its small beginnings the children's department at the Maudsley expanded rapidly in the late 1920s, with referrals rising from 90 in 1924 to 432 in 1931 (Evans *et al*, 2008).

Training of staff for clinical work with children in other centres in Britain also began in the 1920s. The staff at the Tavistock Clinic for Functional Nerve Cases in London, some of whom had experienced the effects of the First World War, established services for civilian adults, but soon also found themselves treating children and publishing related works. Among the latter is *The New Psychology and the Parent* by H. Crichton Miller, the clinic's first director (Barton Hall, 1947).

At this time, Leo Kanner (1894–1981), a psychiatrist born in a small village in what is now Ukraine, left his early career in Berlin in 1924 to establish himself in the USA, founding the children's psychiatric service at Johns Hopkins Hospital in 1930. Recognised as the first 'child psychiatrist', he published *Child Psychiatry*, the first English-language textbook on the subject, in 1935. Known principally for his work on autism, his paper 'Autistic disturbances of affective contact' (Kanner, 1943) was highly influential in the study of this disorder.

The first child guidance clinic in Europe was the East London Child Guidance Clinic, established in 1927 by the Jewish Health Organization and directed by Emmanuel Miller. Miller (1893–1970) is credited with the introduction of the child guidance movement from the USA to the UK, and in 1968 he edited *Foundations of Child Psychiatry*. He helped to establish the Institute for the Study and Treatment of Delinquency and also founded what later became the Association for Child and Adolescent Mental Health. During a demonstration of the work of the East London Child Guidance Clinic reported by *The British Medical Journal* (1936), a Lady Cynthia Colville gave a brief talk on the work of the clinic and how 'Thieving, spiteful, and backward children became transformed after a few sessions at the clinic into normal and happy youngsters, ready to take up life and meet it on its own terms'. Clearly, there was a great deal of optimism in the air.

Similar clinics began to be established elsewhere in the UK as a result of the Commonwealth Fund of 1927, which had been formed by an act of philanthropy. One such was the London Child Guidance Clinic, to which John Bowlby was appointed in 1936. Work at the clinic provided the source for his classic paper 'Forty-four juvenile thieves, their characters and home life' (Bowlby, 1944). Bowlby (1907–1990) was born in London and trained as a psychiatrist as well as a psychoanalyst. His early interest in childhood delinquency later extended to children who were affectionless, hospitalised

or institutionalised. Most known for his work on attachment theory, which was based on a theory of evolutionary adaptation and inspired by the ethological approaches of Lorenz and Tinbergen, his work has been profoundly influential.

### *The Hampstead War Nurseries*

The Second World War is the next milestone, heralding another era of mass movement and social change. In this period in Britain, the many city children who came to be wartime evacuees in the 1940s were found to be in poor health. This was also a time of traumatic loss and separation from family, and this was the context for the establishment of the Hampstead War Nurseries in the winter of 1940–1941 by a group of engaged and energetic colleagues in Anna Freud's circle. Young-Bruehl (1989) gives an account of the nurseries, which were intended to care for children whose families had been broken up in one way or another. The creation of the nurseries also, of course, afforded opportunities for observation and research into children in institutional settings. One of the members of this group, the social worker and film-maker James Robertson, made the classic film *A Child Goes to Hospital*, which did a great deal to challenge restrictive hospital visiting policies.

Wartime research also afforded other discoveries. The tragedy of the famine – known as the hunger winter – in war-time Holland in 1944–1945 led to findings about the influence of starvation on the fetus (although these were not published until much later). The most exposed cohort of individuals conceived at the height of the famine had a two-fold increase in risk of schizophrenia (Susser *et al*, 1996) and it now seems likely that this kind of critical assault on fetal growth is associated with other neurodevelopmental disorders.

### *The postwar period*

After the war, trends in the development of the specialty have included the influence of psychoanalytic ideas, the establishment of in-patient units for adolescents, increasing professionalism of disciplines allied to child psychiatry, teaching and research, an increase in the number of child psychiatrists and a proliferation in treatment approaches. These are all comprehensively discussed elsewhere (e.g. Warren, 1971; Hersov, 1986; Wardle, 1991; Rutter & Stevenson, 2008) and only the first two of these themes will be mentioned here as they are of more importance to the narrative.

Although the role of psychoanalytical thinking and its influence on child psychiatry has been controversial and has attracted vociferous criticism, Adler and Freud, and colleagues who followed them, contributed theoretical concepts and frameworks which led to many developments in practice. For example, Alfred Adler (1870–1937), who fled anti-Semitism

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in Europe in 1935 to migrate to America, made a particular contribution in considering the effect of obstacles to the shaping of the individual child's self-esteem. Karl Abraham (1877–1925) wrote on infantile trauma and manic–depressive insanity; Sigmund Freud (1856–1939), whose many ideas were influential generally in the culture (the significance of the emotional life on the generation of symptoms, the importance of repression and symbolism, the dynamic model of the unconscious, trauma and memory, transference and countertransference, and so on), also extended his work to the realm of childhood. Melanie Klein (1882–1960) elaborated a theory of defences to deal with anxiety and also analysed in great detail the mother–child relationship. Anna Freud (1895–1982), as well as being director of the Hampstead War Nurseries and a training programme for psychoanalytic work with children, wrote on defence mechanisms and the ego. The paper by Rous & Clark (2009) gives a brief overview of the history of the psychoanalytical movement in the NHS and the Freud/Klein controversy, and outlines the contemporary situation of psychotherapy provision in a public service.

In service development, the emergence of adolescent psychiatry as a subspecialty occurred only with the establishment of the first modern in-patient units after the Second World War. These were opened at the Maudsley Hospital in 1947 and St Ebba's Hospital (Epsom, Surrey) in 1949 (later moving to Long Grove in Epsom). The emergence of adolescents as a group recognised as having particular needs and concerns is very recent, and only in the past decade have services been obliged to provide specifically for young people aged between 16 and 18. The opening of these two units marked a shift in thinking at that time. It occurred soon after two other major changes: the birth of the NHS and the reforms recommended by C. P. Blacker in a report commissioned by the Ministry of Health, *Neurosis and the Mental Health Services*, in 1946. In this, he suggested the separation of the child guidance clinics led by psychologists and run by local authorities from the child psychiatry departments led by child psychiatrists and run by health authorities. The conflict over where the specialty belongs is therefore a well-rehearsed one, and child psychiatrists may find it salutary to remind themselves that their path has never been easy and there was no golden age.

## The reformation: community services

Entering a more modern era in the narrative, critics of the child guidance movement were always plentiful and early included those from within the ranks. So, for example, Kanner considered that help provided by child guidance clinics encouraged rigidity and inhibited inventiveness (Warren, 1971) and the Association for the University Teachers of Psychiatry called for their abolition in 1961. Later, the number of critics multiplied and the child guidance approach was seen by many (including Rutter & Stevenson, 2008) to foster professional isolationism as well as lead to



lengthy open-ended treatment. Naturally, the team approach has come under opprobrium too and it is interesting to speculate, as Hersov (1986) does, what would have been the outcome had the team clustered around a prototypical child with neurosis rather than one who was delinquent. An outright critic of more recent times, the historian John Stewart, has blamed child guidance clinics for pathologising childhood, medicalising a whole generation of children and emphasising that problems result from emotional and psychological rather than material causes (such as poverty) (e.g. see Stewart, 2013).

There thus has followed a period of reformation, beginning with the merging of local authority child guidance clinics and in-patient services in 1974 to form community services. Ultimately, we have arrived at the widely misunderstood but much quoted model of a four-tiered provision of services, which began in the 1990s. More recently, a baffling number of policy initiatives have been steadily produced, concisely and helpfully summarised by Cottrell & Kraam (2005) and also by Richardson & Wyatt (2010). It is always to be hoped that social policy can in some way improve the national well-being of children, and the UNICEF report on 21 of the most industrialised nations in 2007 certainly demonstrates that it needs to (UNICEF, 2007). The UK scored particularly poorly at the bottom of a composite chart of indices and was among the nations in which child poverty was above the 15% level. But it has been understood for a long time that the relationship between socioeconomic status and child psychiatric disorder is steeply positive (with a prevalence of disorder of 5% among the children of the professional classes, 15% among those of unskilled workers and 20% among those whose parents have never worked (Melzer *et al*, 2000). It is clearly unfair that children should be so differentially afflicted; unfair that they should be exposed to so little that is nurturing; and frankly often unfair that they are conceived in the first place.

The tension continues over whether child and adolescent mental health services (CAMHS) are part of children's services or part of the health service. Partridge & Richardson (2010) usefully distinguish between the need for society to care for the well-being of its population (universalism, if you like) and the responsibility of CAMHS to attend to mental disorder (which is, after all, a specialty). Professionals in CAMHS cannot be expected to improve the emotional well-being of every child, but child psychiatrists have played and continue to play an important role in their professional lives with this generally disadvantaged group.

## The child psychiatrists of the future

What do we know of the explicitly stated theoretical models that were being used historically? W. S. Dawson, who established the children's department at the Maudsley, had the view that insanity was essentially a disorder of conduct shown by a failure to adjust the self to surroundings. He based this

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belief on a dynamic model in which the instinctive urges are controlled in accordance with social demands (Dawson, 1944). Although interested in an evolutionary perspective and also in Freud, the work he encouraged also had a strong empirical basis. There was systematic recording of information on admission to the Maudsley in the 1930s and children were given full medical, including neurological, examinations (Evans *et al*, 2008). In his view, ‘Intensive study of the child is undertaken in the hope that not only may such nervous manifestations and other behaviour difficulties be handled successfully, but that *the development of neurosis and even of psychosis at a later age may be prevented*’ (my italics) (Dawson, 1944: p. 298).

With the rise of scientific approaches over the past 50 years (e.g. as reviewed by Rutter & Stevenson, 2008), the problem of lack of theory may now be beginning to be resolved. Michael Rutter (b. 1933) – the first Professor of Child Psychiatry in England and head of the first academic department for the specialty at the Maudsley in 1972 (Black & Gowers, 2005) – has done much to establish the specialty on a more rigorous scientific basis. Notable for his interest in epidemiology, Rutter’s comprehensive population surveys in London and the Isle of White published in 1970 are still regarded as classic studies in the field.

The child psychiatrists who shape the future will be specialist doctors who will have a sound grasp of biomedical, neurodevelopmental, psychological and social medicine. They will be informed in behavioural and cognitive approaches, and family and psychoanalytic theories. They will be familiar with the continuity of childhood mental disorder into adult life, and thus the whole range of psychopathology in their patients and in those patients’ families. They will be able to appreciate the influence of the interaction of genes and environment on the developing brain, be confident in psychopharmacology, appreciate how research and evidence can inform practice and remain alert to how findings from neuroscience might shape the specialty. *Clinical Topics in Child and Adolescent Psychiatry* has been edited with them in mind, with the aim of contributing to a developmental understanding of our specialty as well as of our patients.

TYRONE: Mary! For God’s sake, forget the past!

MARY (with strange objective calm): Why? How can I? The past is the present, isn’t it? It’s the future, too. We all try to lie out of that but life won’t let us.

Eugene O’Neill, *Long Day’s Journey into Night*, 1956

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## CHAPTER 2

# Fabrication and induction of illness in children

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In the fabrication or induction of illness in children, an adult – characteristically a parent and usually the mother – presents a child to healthcare professionals as ill when in fact the symptoms of the illness are falsified, fabricated or actively induced by the adult. There have been many changes in nomenclature since Meadow first described this manifestation of disturbed parenting and caregiving as ‘Munchausen syndrome by proxy’ (Meadow, 1977). Other terms have since been introduced, including ‘factitious disorder by proxy’ (DSM-IV: American Psychiatric Association, 1994), ‘factitious disorder imposed by another’ (DSM-5: American Psychiatric Association, 2013), ‘paediatric condition falsification’ (Ayoub *et al*, 2002) and, in the UK, ‘factitious or induced illness’ (Department of Health, 2002). The term ‘medical child abuse’ has also been used in the USA (Roesler & Jenny, 2009), to reflect the role of the doctor in ordering interventions and procedures that are invasive and unnecessary, which (inadvertently) maintain the abuse. In this chapter, we will use the term ‘fabricated or induced illness by carers’ (FII), which has also been adopted by the Royal College of Paediatricians in the UK (Royal College of Paediatrics and Child Health, 2009). In practice, however, the majority of perpetrators (85%) are parents.

All of these definitions have limitations because they attempt to describe a spectrum of abnormal illness behaviour involving a perpetrator and how this behaviour affects a child. Abnormal healthcare seeking behaviour in the perpetrator can range from hypervigilant preoccupation with a child’s symptoms at one end of the spectrum through to intentional induction of illness or poisoning of the child at the other. However conceptualised, FII is a form of child abuse that involves an abnormal form of care-eliciting behaviour in the caregiver, usually manifested as an abnormal relationship with healthcare professionals that has an adverse effect on the child.

## Epidemiology

The incidence of FII is unknown, but the behaviour is widely believed to be underreported. In 1996, the combined annual incidence of identified FII,

non-accidental poisoning and non-accidental suffocation in the UK and Ireland among children 5–16 years of age was 0.5 per 100 000; among those 1–4 years old it was 1.2 per 100 000; among those 0–11 months old it was 2.8 per 100 000; 8 deaths were recorded (McClure *et al*, 1996). Watson *et al* (1999) studied children who had experienced ‘parental abnormal illness behaviour’ and reported an incidence of FII, non-accidental poisoning and non-accidental suffocation of 89 per 100 000 under-16-year-olds over a 2-year period in the Manchester health district, but no mortality. Denny *et al* (2001) in New Zealand reported an incidence of FII of 2.0 per 100 000 children under the age of 16 and of 1.2 per 100 000 using the same criteria as McClure *et al*, but found no deaths.

These figures are likely to be an underestimate of the true incidence. Detection can be difficult, especially in cases that involve false accounts of symptoms or fabricated symptoms (such as tampering with a child’s specimens). Induced illness, which results in greater morbidity or even death, may be more easily detected, although there remain concerns that some types of sudden death in children may be the result of this form of child abuse (Craft & Hall, 2004; Galvin *et al*, 2005).

Fabricated or induced illness is most often seen in children under 5 years of age who are unable to verbalise their own problems. Older children are also affected, and they may actively collude with their parents in the sick role. Boys and girls are equally affected, and FII is perpetrated by all social classes. The average age at which FII is diagnosed is 48.6 months (range 0–204 months), with an average interval between the onset of symptoms and diagnosis of 21.8 months (range 0–195 months) (Sheridan, 2003).

## Manifestations of abnormal caregiving behaviour

The complex ways in which a parent can respond to a child’s symptoms is shown Figures 2.1 and 2.2. It is clear that a range of behaviours involve healthcare professionals and result in a variety of outcomes for the child. These include:

- overconsultation with healthcare professionals (compared with normative rates), refusal to accept a diagnosis or comply with suggested treatments and persistent antagonism towards healthcare professionals
- exaggeration of existing symptoms
- providing false accounts of non-existent symptoms (e.g. ‘he keeps having fits’, ‘she suddenly stops breathing’)
- fabrication of symptoms (e.g. contaminating body fluids used for medical investigation by putting substances in a child’s urine sample to simulate illness)
- actively inducing symptoms, which involves either direct or indirect behaviour that causes physical harm (e.g. administering medications inappropriately, smothering to simulate apnoeic attacks, tampering with hospital equipment).

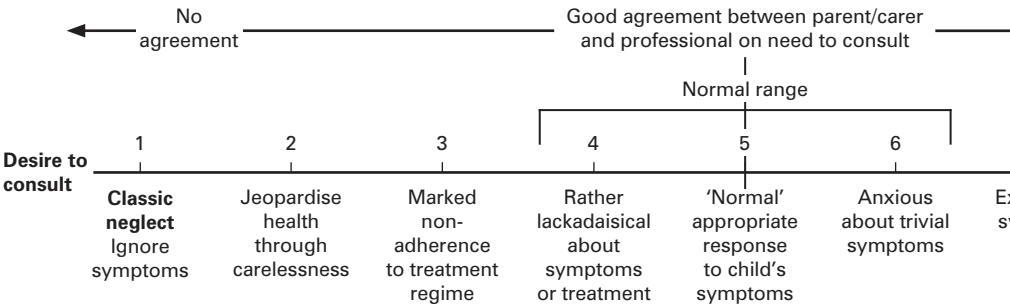


Fig. 2.1 The spectrum of healthcare seeking by parents for their children. After Eminson (2000), w

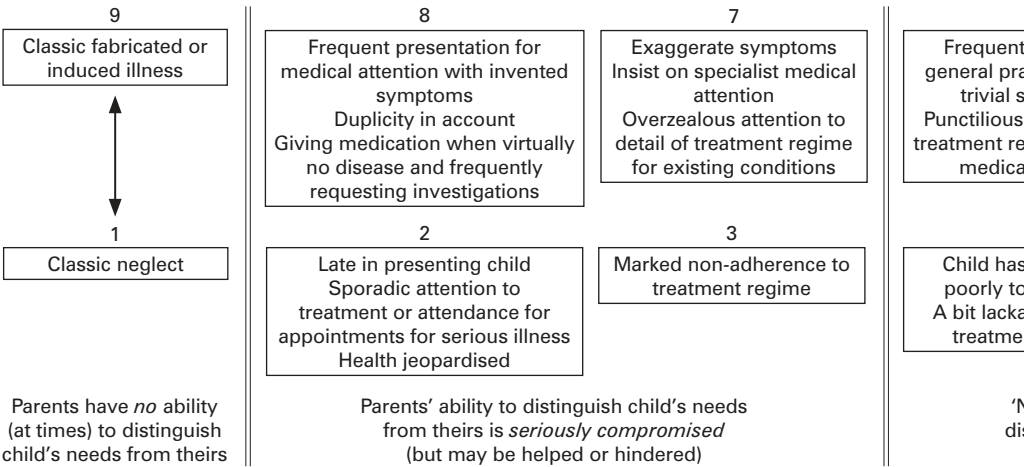


Fig. 2.2 Parents' desire to consult for their child's symptoms. After Eminson (2000), with permission

It is not known whether there is an escalation from milder to more severe forms of behaviour. It is known, however, that mild forms may coexist with more severe forms.

Although it is the induction of illness that usually carries the greatest risk of serious physical harm to the child, children can also suffer harm as a result of the repeated inappropriate investigations (such as lumbar punctures), unnecessary medical interventions (such as oesophageal reflux surgery) or the administration of medication that the false accounts or fabricated signs or symptoms bring about.

One of the most problematic aspects of this behaviour is that general practitioners, accident and emergency (A&E) staff and paediatricians may unwittingly be involved in causing potentially dangerous iatrogenic complications (Roesler & Jenny, 2009).

## Impact on children

In her literature review of 451 cases of FII, Sheridan (2003) reported that 27 (6%) of the children died and 33 (7%) suffered long-term or permanent injury. Over half of children subjected to FII suffer indirect psychological harm, including emotional abuse or neglect, which can be manifested in behavioural problems, school non-attendance and major concentration difficulties. Furthermore, affected children live in a fabricated sick role and may eventually simulate illness in themselves, sometimes continuing the behaviour into adulthood (Sanders, 1995). Some suffer persistent consequences into adolescence, even in the absence of the original perpetrating parent (Shapiro & Nguyen, 2011). Three-quarters of index children are affected by other forms of maltreatment, physical abuse, neglect, further fabrications or inappropriate medicating (Bools *et al*, 1992).

## Social and demographic characteristics of perpetrators

People who fabricate or induce illness in children are nearly always female. Sheridan's review (2003) reported that 76% of the perpetrators were the biological mother and 7% the father. Between 14 and 30% had ties to the healthcare profession. Some professional carers have been reported to abuse those dependent on them, which again suggests that the reciprocal role relationships may be important for this type of abuse (Adshead & Bluglass, 2004). Unlike other types of child abuse, FII seems to be perpetrated by all social classes, is not always associated with other types of family violence or crime, young, inexperienced parents or socioeconomic deprivation. In one series of 41 children from 37 families there were high rates of privation, childhood abuse and significant loss or bereavement in the 34 mothers who were responsible for the fabrication or induction of illness. Only 4 (11%)

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of these parents (including 2 fathers) were employed (Gray & Bentovim, 1996). Furthermore, a later case series, of 28 women (Bass & Jones, 2011), reported that a majority of perpetrators were either unemployed (53%, or 15 individuals) or in receipt of long-term disability living allowance (25%, or 7 individuals), and had a mean age of 31; 39% (11 individuals) had spent time in foster care.

Potentially relevant psychosocial factors include the following.

### *Childhood sexual and physical abuse*

In the Bass & Jones (2011) case series, 15 (54%) of the 28 women had had severe abusive experiences in childhood. Childhood sexual abuse was reported by 12 (43%) participants and severe physical abuse by 7 (25%). Of note was the fact that from an early age some participants began to feign symptoms in order to avoid beatings or to prevent visits with abusive parents/carers.

In the 37 sets of parents studied by Gray & Bentovim (1996), 8% had experienced physical abuse and 35% emotional deprivation. None had a history of sexual abuse – perhaps because the series began in 1984, when sexual abuse was less discussed.

### *Marital and family difficulties*

In Gray & Bentovim's sample, 40% reported serious marital problems, often of long duration, on admission or in subsequent therapy sessions. Of note is that these problems had previously been denied or minimised. One quarter of the mothers seemed to use the child's illness concerns as a way of re-engaging the fathers, who in 70% of cases were either absent or peripheral to the family system.

### *Bereavement*

The Gray & Bentovim study reported that 14% of mothers had experienced a loss or bereavement involving children in the perinatal period (difficulties in conception, miscarriage, stillbirth or death); 11% of these mothers had experienced at least one bereavement of a significant adult (parents or supportive family member) and 32% had experienced the loss of a partner through either separation or divorce. One-third to a quarter of these mothers had suffered two or more of these types of difficulty. A study of attachment in 67 mothers who had demonstrated FII found that a high number had experienced unresolved distress and bereavement (Adshead & Bluglass, 2005).

### *Other factors*

Other parental factors associated with abnormal illness behaviour in children include somatoform disorder, factitious disorder, being in receipt of disability living allowance, keeping children home from school,



frequent visits to doctors with unexplained symptoms and failure to attend appointments (Bass & Jones, 2011).

Assessors should also note any frequent house moves, registration with new general practitioners and attempts to register for disability living allowance for the child. It is important to note that the parents of children who are victims of serious and substantiated physical abuse and neglect change their child's primary care provider more frequently than those of non-abused children (Friedlaender *et al*, 2005). It is essential therefore that full copies of the child's medical and general practitioner records are made available when interviewing a suspected perpetrator of FII.

## Psychopathology of the fabricators

It may be helpful to consider the psychopathology of child abusers more generally, and then to focus on mechanisms that may give rise to this particular form. Fabricated or induced illness by carers of children is exploitation of the vulnerable, and potentially criminal behaviour. Child abuse is not associated with any specific psychiatric diagnosis, and it can occur in the absence of diagnosis. Most studies of child abuse by parents emphasise abnormalities in the parent–child relationship which are usually present from birth. Child abuse is more common among younger parents who have insecure backgrounds, are ambivalent about parenthood, and who have unplanned babies who are unwell or disabled (Paz *et al*, 2005).

Perpetrators of FII have been diagnosed with a range of psychiatric diagnoses, the most common of which are discussed here.

### *Somatoform and factitious disorders*

Some researchers have noted the role of somatising behaviour in perpetrators, i.e. the tendency to express their anxiety physically, and have suggested that the mothers were treating their children as an extension of their own bodies. Bools *et al* (1994) found a high prevalence of somatising and factitious disorders in their sample, and Gray & Bentovim (1996) reported that 38% of mothers described medical problems of various degrees of severity. In 3% there was evidence of hypochondriasis and in 16% there was evidence of chronic factitious disorder. Bass & Jones (2011) reported 57% with somatisation disorder, 65% with fabricated or factitious disorder and 39% with both.

These findings are not unexpected, as there is evidence that somatising behaviour in adulthood is associated with adverse experiences of care and illness in early childhood (Craig *et al*, 2002). The distinction between somatising disorders and factitious disorders is chiefly one of perceived and conscious motive (Bass & Jones, 2011). In somatising disorder, the adult is not consciously or deliberately fabricating but is gripped by a conviction that they have a serious physical disorder. In factitious disorders, it is thought that an individual who fabricates, induces or even exaggerates is consciously

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choosing this behaviour or at least consciously aware of the deception and possible gains involved. In practice, this distinction of motivation may be hard to detect.

Of the medically unexplained symptoms reported by somatising mothers, a high proportion are 'pseudoneurological' (faints and pseudoseizures), gastroenterological (abdominal pain and nausea), and obstetric and gynaecological (Bass & Jones, 2011). It is of interest that the symptoms most commonly fabricated in children by carers are epilepsy and syncope (Barber & Davis, 2002).

### *Affective and psychotic illnesses*

Gray & Bentovim (1996) reported that 43% of their sample had a history of depression. Only 5% had been treated for psychotic illness, namely schizophrenia and bipolar affective disorder.

### *Personality disorder*

Personality disorder is reported as highly prevalent in child abusers generally (Dinwiddie & Bucholz, 1993). However, there is a danger of circularity of argument, because the diagnosis of personality disorder is based on the abusive behaviour. It is likely that some types of personality disorder (for example, antisocial personality disorder) are a risk factor for child abuse generally, but the diagnosis alone provides little information.

This point is of particular relevance in cases of FII. More than one study found high rates of emotionally unstable personality disorder, borderline type, in fabricators, at times also associated with other types of personality disorder (Bools *et al*, 1994; Bass & Jones, 2011). However, it would be misleading to suggest that borderline personality disorder causes the behaviour, since so many mothers with borderline personality disorder do not abuse their children in this way. Nevertheless, borderline personality disorder is associated with a variety of parenting problems (Hobson *et al*, 2005), almost certainly mediated through the attachment style of affected parents (see below).

### **Motivation and triggers**

The issue of motive has been a major cause of debate among workers in this field. Meadow's original contention was that the mothers carried out this behaviour to draw attention to their own needs and distress. Authors such as Schreier & Libow (1994) have suggested that the mothers form disturbed relationships with healthcare professionals that replicate past disturbed relationships with carers. Of relevance here may be that some case series have revealed that many of these mothers themselves experienced childhood abuse (Bools *et al*, 1994; Gray & Bentovim, 1996; Adshead & Bluglass, 2005). However, a history of childhood abuse is neither necessary

nor sufficient to explain FII, since most adult survivors of abuse do not abuse their children.

Gray & Bentovim (1996) suggested that early stressful and traumatic events experienced by parents contribute to an ambivalent attitude and grievance towards the child and a perception that the child is ill. The seeking of medical assistance in the belief that the child is ill is then seen as a way of receiving help themselves.

It has also been suggested that FII represents an abnormality in the attachment system between mother and child, which regulates caregiving and care-eliciting behaviours (George & Solomon, 1996). Attachment insecurity is overrepresented in maltreating parents, including those who perpetrate FII, compared with non-clinical samples (Adshead & Buglass, 2004, 2005) and is associated with hostile and helpless states of mind (Lyons-Ruth *et al*, 2006). An attachment perspective may also be relevant because of the known influence of insecurity of attachment on medically unexplained symptoms and abnormal illness behaviour. Ciechanowski *et al* (2002) found that patients with preoccupied and fearful attachment reported significantly more physical symptoms compared with secure patients. Controlling for age, income and recent experience of violence by an intimate partner, Waldinger *et al* (2006) showed that fearful attachment fully mediated the link between childhood trauma and somatisation among women.

Some believe that FII is a form of complex deceptive behaviour. Scrutiny of Social Services records or discussions with relatives or other informants, such as the general practitioner, may reveal a history of lying. Pseudologia fantastica is a dramatic form of pathological lying in which grandiose stories are constructed, often built on a matrix of truth (Dike *et al*, 2005). Unlike a person with delusional psychosis, someone with pseudologia fantastica will abandon the story or change it if confronted with contradictory evidence or sufficient disbelief. Bass & Jones (2011) reported that 61% of their sample exhibited lying or fabrication of stories.

## The role of the psychiatrist

### *Investigation*

Strictly speaking, the psychiatrist has no role to play until FII has been identified and confirmed. However, because it may be difficult for child protection services to gather actual evidence, professionals may put pressure on psychiatrists to state whether or not FII has taken place. This should be resisted, because of the risk that the psychiatrist might step outside their legal area of expertise. Ideally, psychiatric assessment will not take place until the paediatric review has confirmed that there is no organic cause for the child's illness or presentation and/or until there has been a legal fact-finding hearing. If the alleged perpetrator is denying the

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behaviour, then the assessing psychiatrist should prepare two opinions: one based on a perpetrator being found to have carried out the behaviour; one based on a situation where there is no perpetrator identified. Psychiatrists who state their opinion about the guilt of an alleged perpetrator may find that they interfere with any criminal justice proceedings, and risk being referred to the General Medical Council.

The assessment process relies heavily on paediatric assessment and investigation, and the exclusion of other causes for the child's 'symptoms'. However, psychiatrists (either from liaison or child psychiatry) may be called in to assess parents who have a history of psychiatric disorder, usually in the context of risk assessment. In such circumstances, it is important for the psychiatrist to remind colleagues that a psychiatric history does not automatically make a parent more likely to abuse their child, nor does it mean that all of their concerns about their child will be abnormal. Specifically, it is important to state that a history of borderline personality disorder, factitious disorder or a somatoform disorder does not necessarily help to identify FII.

Psychiatrists should be especially wary of accepting instructions in legal proceedings (either family or criminal) where FII is suspected, but has not been confirmed as legal fact. Psychiatrists may come under enormous pressure to provide an opinion as to whether a parent 'has FII' and therefore, by inference, has carried out the behaviour in question (Adshead, 2005). Since there is no evidence base that supports a link between any psychiatric diagnosis and either past or future abusive behaviour, it would be highly misleading for psychiatrists to offer any opinion until the facts about the identity of the perpetrator have been established. It must be remembered that there is no adult diagnosis of 'FII in children' (or of Munchausen syndrome by proxy), so it is not possible to say that a mother 'has' this, especially not on the basis of a single interview conducted in an out-patient department.

### *Assessment*

Both adult and child psychiatrists have important roles to play in the management of identified cases in which illness has been fabricated or induced in a child. When decisions are being taken about the care of children involved, adult psychiatrists may be asked to assess the risk posed by both the abusing and the non-abusing parent.

#### **Assessment of the child**

Child psychiatrists may be asked to provide assessments of family dynamics and parenting skills, opinions about the possibilities of family interventions and support, assessments of the effects of the behaviour on the child, and treatment for both the child and the other family members.

Sanders & Bursch (2002) offer useful guidelines for conducting assessments of possible FII at the request of the courts. In all but the

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mildest of cases, the child is separated from the potentially fabricating adult until the risk and prognosis are fully established. The domains assessed are: child, parent, parent–child, family, social and professional; and in all these domains there are factors with better and worse outcome prognosis (Jones & Bools, 1999). The criteria for evaluation of whether change has occurred and interventions have been successful or not should also be established at the assessment stage (Jones *et al*, 2000).

### Assessment of the adult(s)

The assessment of the perpetrating parent is a complex process that requires the collection of information from a wide variety of sources, with the parent's consent. It is essential to read the medical records of the parent (both hospital and primary care) and also, if possible, of the abused child or children. Specifically, it may be useful to look at hospital attendance rates and put these in context of the other events in the parent's life. Relevant Social Services records should be accessed and, if possible, any criminal record. The amount and type of information available will depend to some extent on the context in which the assessment is taking place: most commonly, it will be in the context of care proceedings, where the parent's solicitor may have to be approached to gain access to both health and criminal records.

Both adult and child psychiatrists may find themselves in situations where they are interviewing a parent who is only suspected of having fabricated or induced illness in their child, i.e. it has not yet been proven. If this is the case, then the process of preparation before interviewing the parent is especially important and complex (Box 2.1).

#### **Box 2.1** Assessment of a parent/carer under suspicion

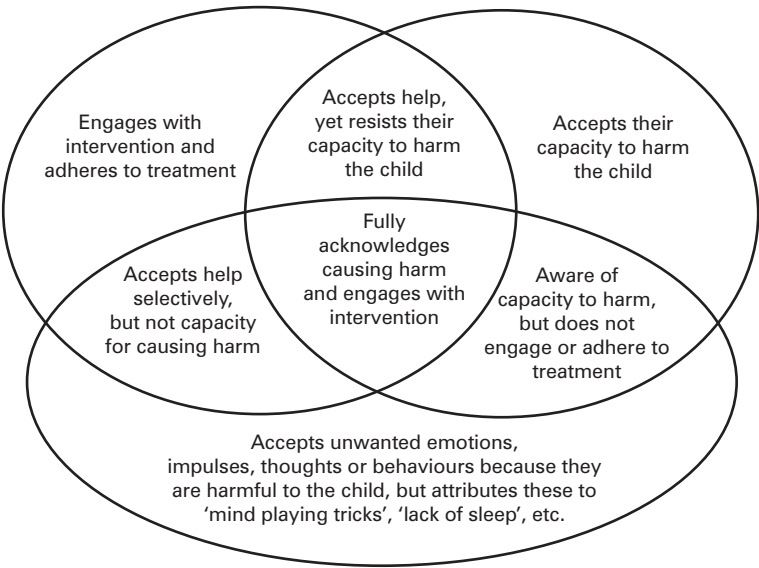
Preparation for the assessment of a parent/carer suspected of inducing or fabricating illness in a child should ideally include:

- the parent/carer's medical records (hospital and general practitioner records, both paper and electronic)
- the child's medical records
- social work records/reports
- police records/videos
- legal documents (mother's and father's statements; reports written by the child's guardian *ad litem*)
- interview with the parent and partner (audiotaped, with consent)
- interview with the grandparents (audiotaped, with consent)
- telephone interview with general practitioner, social workers, paediatrician and guardian.

Information gathering will also include interviews with key informants such as social workers and the child’s grandparents. Evidence of inconsistencies in the medical history, comments from medical practitioners and social workers about parenting skills, episodes of antisocial behaviour and dissimulation or frank lying might be revealed. It is also important to establish whether the parent acknowledges any of the concerns and is willing to commit to therapeutic work to change their behaviour. This will have a major impact on outcome (Fig. 2.3) in the long term (Bools, 2007).

Psychiatrists are often asked to provide opinions about the parenting capacity of a parent suspected of this type of abuse or of the non-abusing parent. It is important that psychiatrists who do this have expertise in the field. This usually means that they are child psychiatrists. Adult psychiatrists should not offer expert opinions about parenting capacity unless they: (a) have the skills to carry out a thorough parenting assessment; and (b) can demonstrate to the courts exactly how they have done so. Parenting capacity or its absence cannot be established by an ordinary psychiatric interview of the adult alone: it usually includes assessment of the parent with the child, and information from foster carers or those who supervise contact.

Some screening tools may be of assistance. The Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) and the Parental Bonding Instrument (PBI; Parker *et al*, 1987) may provide an indication of the parent’s attachment security. It may be useful to assess for any disorder of personality either using the Structured Clinical Interview for



**Fig. 2.3** The main components of acknowledgement. Adapted by D. Jones from David (1990), with permission.



DSM-IV Axis II Personality Disorders (SCID-II; First *et al*, 1997) or the International Personality Disorder Examination (IPDE) screening versions (Loranger, 1999). It is important to make clear in any report that these are not diagnostic tools and that they cannot provide confirmatory or refutatory evidence where the facts are disputed.

## Management

Detection of FII usually results in care proceedings to determine whether the abusing parent should continue to care for the child. In most cases, courts will place the child in the care of the non-abusing parent (if separated), grandparents or the local authority. Abusing parents may or may not have contact or access, depending on individual circumstances.

For parents who are found by the court to have harmed their children, there are usually two issues at stake. First, they may need an assessment of parenting capacity in relation to their other children, and this may require admission to a residential family unit. Then there is the issue of whether reunification of the family is possible. This will depend on the assessment of risk to the child, and the attitudes of the parent to working with professionals, including therapists.

## Treatment for parents

### When parent and child are permanently separated

There are a very few specialist services that can provide treatment for both perpetrator and child where there has been severe parenting breakdown. Often, the parent will be rejected by regular psychological therapy services as being too disturbed, but is not disturbed enough to reach criteria for the intervention of forensic services.

Most parents will need treatment for both mood disorders and personality disorders, usually of the emotionally unstable, borderline type. There has been considerable expansion of treatment services for personality disorders, and there is ample evidence that personality pathology responds to treatments that address affect and arousal regulation, such as dialectical behaviour therapy (DBT) and mentalisation-based therapy (MBT) (National Collaborating Centre for Mental Health, 2009). Studies of the treatment of patients with emotionally unstable personality disorder have demonstrated that, although many patients report substantial reductions in symptom severity, improved social and vocational function are more difficult to achieve (National Collaborating Centre for Mental Health, 2009; Gunderson *et al*, 2011; Bateman, 2012).

In addition to treatment for the underlying condition, perpetrators need therapy to address the impact of harming a child, as well as the effect of the loss of that relationship. Therapy needs to address feelings of guilt, shame and sometimes associated suicidal thoughts. It is worth noting that where feelings of guilt and shame are wholly absent, the perpetrator's capacity to

mentalise the effect of the harm on the child needs to be questioned and explored. It is also fundamental to consider the child's protection from future harm, protecting other children (decision-making regarding risk to siblings and/or the public) and ensuring that the parent is supported and/or treated to help them deal with the public consequences of having their child or children taken from them.

As for all psychological therapies, successful treatment requires both engagement with and commitment to therapy. Personality pathology is treatable (National Collaborating Centre for Mental Health, 2009), but psychological therapies are not indicated for individuals who are so deceptive that they cannot establish a therapeutic alliance. In addition, individuals who cannot admit their behaviour present almost insurmountable obstacles to psychological therapy. However, if the individual is willing to engage in psychological treatment, the initial focus of therapy must include their acknowledgement of their behaviour.

### **Where reunification of parent and child is planned**

Where reunification is to be considered, assessment and treatment of the parent-child relationship is essential. The courts seek psychiatric advice on whether the abusing parent can be sufficiently rehabilitated to be reunited with their child and the rest of the family. As suggested above, where there is frank denial of the behaviour or other evidence of antisocial attitudes or cruelty, this is not likely to be possible. In about 20% of cases, the abuse recurs if the child remains with the parent who abused them (Bools *et al*, 1993). Other siblings are also at risk.

However, there is evidence that reunification of families is sometimes possible and successful. A study by Berg & Jones (1999) followed all 17 children from 16 families selected for admission to a specialist residential family unit between 1992 and 1996. There was one recurrence of FII, leading to mild harm to the child. A favourable outcome was associated with: acknowledgement of fabrication and the psychosocial context within which it occurred; less severe abuse; improvements in the parent's psychological functioning and empathy for the child; and improved parent-child relationships and child attachment behaviour towards the parents. A better outcome was seen where changes in the family system and a therapeutic alliance with the fabricator's partner and extended family could be established. For more delineation of prognostic factors see Jones & Bools (1999) and Jones *et al* (2005).

Careful assessment is needed before selecting families for possible intervention. The initial assessment (Jones *et al*, 2000) should determine the degree and quality of the acknowledgement of abuse by the perpetrator, their partner and the wider family, and an assessment of their willingness and individual capacities to engage in a programme of risk management and treatment. Further factors that influence selection include the potential for working in partnership and the existence of better prognostic features.

## Conclusion

Fabricated or induced illness by carers is a rare but serious disorder that has adverse effects on a child's health and development, and can be fatal. It usually involves abnormal illness behaviour in the perpetrator (most often the mother, but rarely a professional carer) and there is evidence of high rates not only of somatoform and factitious disorders, but also of coexisting personality disorders in the perpetrators. The symptoms that are fabricated or induced in the children can on occasion resemble the somatic complaints reported by the mother, and early identification is key if harm to the child is to be avoided. The recently updated guideline on identifying child maltreatment provides helpful information (National Institute for Health and Clinical Excellence, 2013: paras 1.2.11–1.2.12).

Assessment in suspected cases is labour intensive, and professionals should expect to spend considerable time collating material and collaborating with other parties. An attempt should be made to assess the degree to which the perpetrator acknowledges the abusive behaviour, as without this any chance of reuniting the perpetrator and child is negligible. Assessments of parenting capacity and parent–child interaction may be needed to determine whether reunification is viable, but this must take into consideration the timescales for the child. Close collaboration between professions is essential, not only between different medical disciplines but also social services and schools. Collation of material from a variety of different sources is required before reports to the court can be prepared.

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